STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155505	B. WING		01/09/2015
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		OBIN RUN W	
ROBIN R	RUN HEALTH CEN	TER		NAPOLIS, IN 46268	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000000					
			E000000		
			F000000	The following is the Plan of	
		or a Recertification and		Correction for Robin Run Health	
	State Licensure	Survey.		Center regarding the Statement of Deficiencies dated 12/19/2013. This	ic .
				Plan of Correction is not to be	
	Survey dates: Ja	anuary 5, 6, 7, 8, <b>&amp;</b> 9,		construed as an admission of or	
	2015.			agreement with the findings and	
				conclusions in the Statement of	
	Facility number	:: 001156		Deficiencies, or any related sanction	n
	Provider number			or fine. Rather, it is submitted as	
	AIM number: 1			confirmation of our ongoing efforts	
	7 this number. 1	00123330		to comply with statutory and	
	Survey Team:			regulatory requirements. In this	
	1	DN TC		document, we have outlined specific	lC
	Kewanna Gordo			actions in response to identified issues. We have not provided a	
	Megan Burgess			detailed response to each allegation	n
		er, RN (1/7, 1/8, 1/9,		or finding, nor have we identified	
	2015)			mitigating factors. We remain	
	Tracina Moody	, RN		committed to the delivery of quality	,
				health care services and will	
	Census bed type	e:		continue to make changes and	
	SNF: 20			improvement to satisfy that	
	SNF/NF: 58			objective.	
	Total: 78				
	Census payor ty	pe:			
	Medicare: 11	1			
	Medicaid: 38				
	Private: 24				
	Other: 5				
	Total: 78				
	The second of	in an Charlest at the Co. 1.			
		ies reflect state findings			
	cited in accorda	ince with 410 IAC			
LABORATOR	I RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	COMPLETED	
		155505	B. WIN			01/09/	2015	
	ROVIDER OR SUPPLIER UN HEALTH CENT		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	REGULATORY OR  16.2-3.1.  Quality review of Brenda Marshall  483.15(b) SELF-DETERMIN MAKE CHOICES The resident has to activities, schedule consistent with his assessments, and with members of the about aspects of his that are significant.  Based on record the facility failed for showers, walk times were assess reviewed for choose includes.  Findings included During an interval., Resident #	ompleted 01/12/2015 by, RN.  ATION - RIGHT TO  the right to choose es, and health care or her interests, plans of care; interact the community both inside cility; and make choices his or her life in the facility to the resident.  Teview and interview, to ensure preferences are up times, and bed sed for 1 of 2 residents brices. (Resident #124).	F00		It is the practice of the provide assess preferences initially an periodically thereafter. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #124 has been interviewed regarding bathing and sleep-time preferences, and reasonable accommodations have been made. How other residents having the potential to be	r to d		
	based on their sc	hedule and had not ences when she was			affected by the same deficier practice will be identified and	i		
	•	esident indicated she did			what corrective actions(s) wi be taken? Cognitively intact	11		
					residents have been interviewe	ed		
		many times a week she			regarding bathing and sleep-til			
		ne time of the day, or the			preferences, and reasonable			
	•	. She indicated the staff			accommodations have been			
	scheduled her sh	ower days and time. She			made. What measures will be			
					put into place or what systen	nic		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED
		155505	B. WIN			01/09/2015
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER					
DODINID		TED			OBIN RUN W	
KORIN K	RUN HEALTH CENT	ER		INDIAN	APOLIS, IN 46268	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)				DATE
	indicated if she a	sked for additional			changes will be made to	
	showers the staff	f indicated their schedule			ensure that the deficient	
	would not permi				practice does not recur?	
	would not permi	t it.			Residents will be interviewed a	as a
					part of the admission process,	
		14 a.m., Resident #124's			and per the comprehensive MI	DS
	record was revie	wed. The admission			schedule thereafter, about	.
	evaluation data f	form, dated 12/31/14 at			aspects of life in the facility tha	•
		ited the resident was alert			are significant to the individual and reasonable individualized	
		person, place, and time.			accommodations will be made	
	_	form indicated the			How the corrective action(s)	
					will be monitored to ensure t	he
		e to be understood and			deficient practice will not rec	
	understood other	s. The resident's usual			i.e., what quality assurance	,
	and customary p	references for bathing,			program will be put into place	e?
	bed time, and ris	e time were not			A Quality Assurance Performa	
		e evaluation form.			Improvement audit tool will be	
	F	• • • • • • • • • • • • • • • • • • • •			utilized weekly times 4 weeks,	
	The core plan de	ated 1/2/15, did not			then bi-weekly times 4 weeks,	
	_				and then at least quarterly	
		ident's preferences for			ongoing. The Quality Assuran	
	bathing, wake up	time, or bed time.			Performance Improvement aud	
					will be reviewed by the monthly Quality Assurance Performance	
	The "Patient's Ba	ath/Shower Record,"			Improvement committee. By	, <del>c</del>
		manager (UM) #3, on			what date will the systemic	
	l	.m., indicated the			changes be completed?	
		eduled to have showers			February 1, 2015	
					1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
		and Saturdays during the				
	evenings.					
	The admission m	ninimum data set (MDS)				
		not yet been completed.				
	assessificit flag	iot j ot occir completed.				
	Danima a su int	: 1/00/15 2:42				
	_	iew on 1/08/15 at 3:43				
	_	strator indicated Resident				
	#124's preferenc	es for showers, bed				
	times, and wake	up times would most				

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION		A. BUI	LDING	00	COMPL 01/00	
		155505	B. WIN	G		01/09/	/2015
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
ROBIN R	UN HEALTH CENT	ER			OBIN RUN W APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	,		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
	likely be docume	ented in the social service					
		acorporated into the care					
	plans.	P					
	F						
	During an interv	iew on 1/09/15 at 11:59					
	_	icated a resident's					
	· ·	hower times and wake					
	*	valuated within 48 to 72					
	*	on. She indicated they					
		eir preferences during the					
	<u> </u>	at on admission and there					
		ne form for them to					
	•	nation. She indicated					
	they only asked	a resident's preference on					
		ay they preferred					
		the days of the week					
		ifficult with the number					
		ccommodate the day of					
		. She indicated usually					
		y cared about the time of					
	l '	the day of the week.					
		•					
	During an interv	iew on 1/09/15 at 12:26					
	_	strator indicated the					
	_	ence assessment was					
	•	hin 7 days of admission					
	<u>-</u>	the resident's preferences					
		wake up times. She					
		ould verify it had been					
	completed for Re						
	-						
	During an interv	iew on 1/09/15 at 1:20					
	p.m., the admini	strator indicated the form					
	entitled, "Reside						
							<u> </u>

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	00	(X3) DATE SURVEY  COMPLETED
	155505	A. BUILDING B. WING		01/09/2015
			ADDRESS, CITY, STATE, ZIP CODE	l
NAME OF F	ROVIDER OR SUPPLIER		OBIN RUN W	
ROBIN R	UN HEALTH CENTER	INDIAN	APOLIS, IN 46268	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
1710	preferences for customary routine and	IAG	·	DATE
	activities for MDS," was completed on			
	1/9/15 after UM #3 and administrator had			
	been made aware the resident had not			
	been asked preferences on admission.			
	On 1/09/15 at 2:29 p.m., the			
	administrator provided the current policy			
	entitled, "Quality of Life-Self			
	Determination and Participation." The			
	policy indicated a resident should be allowed to choose his/her activities,			
	schedules, and health care in order to be			
	consistent with his/her interests. The			
	policy indicated the preferences should			
	be assessed on initial assessment and			
	periodically thereafter and should include			
	sleeping and bathing schedules.			
	3.1-3(u)(1)			
F000279	483.20(d), 483.20(k)(1)			
SS=D	DEVELOP COMPREHENSIVE CARE PLANS			
	A facility must use the results of the			
	assessment to develop, review and revise			
	the resident's comprehensive plan of care.			
	The facility must develop a comprehensive			
	care plan for each resident that includes			
	measurable objectives and timetables to meet a resident's medical, nursing, and			
	mental and psychosocial needs that are			
	identified in the comprehensive assessment.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155505		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 01/09/2015	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	CROSS-REFERENCED TO THE APPRO	BE COMPLETION
	that are to be furred the resident's high mental, and psycherequired under §2 that would otherw §483.25 but are resident's exercisincluding the right §483.10(b)(4). Based on record the facility faile comprehensive dialysis treatme practice had the resident reviewed (Resident #123). Findings included Resident #123 to, Stage IV CK Disease) and the resident received days a week.  The treatment resident received the treatment resident received the resident received the treatment resident received the treatmen	care plan related to ints. This deficient potential to affect 1 of 1 ad for dialysis care plan  :  s:  s:  s:  record was reviewed on m. The resident's led, but was not limited D (Chronic Kidney ercord indicated the d Hemodialysis three  ecord, dated indicated the AV fistula alysis) was supposed to y and the thrill palpated 3 The record did not lity had developed a care	F000279	It is the practice of the providevelop a comprehensive oplan related to dialysis treat as applicable to the individuation resident. What corrective action(s) will be accomplifor those residents found have been affected by the deficient practice? Reside #123 has been discharged the community. How other residents having the pote to be affected by the same deficient practice will be identified and what correct actions(s) will be taken? Fresidents receiving dialysis comprehensive care plant addresses dialysis. What measures will be put into or what systemic changes be made to ensure that the deficient practice does not recur? For all resident recedialysis, the comprehensive plant will address dialysis. If the corrective action(s) will monitored to ensure the deficient practice will not i.e., what quality assurance program will be put into p	care tment ual  shed to ent from  ntial e  ctive For all , the  place s will e civing e care How ill be recur, ce

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	UILDING 00		COMPLETED	
		155505	B. WIN	G		01/09/	2015
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
TWINE OF T	NO VIDEN ON BOTTEIEN		6370 ROBIN RUN W				
ROBIN R	UN HEALTH CENT	ER		INDIAN.	APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	A Quality Assurance Performa	200	DATE
		led Nurse's Note, " dated			Improvement audit tool will be	rice	
		m., indicated, "Received			utilized weekly times 4 weeks,		
		portation that Dialysis			then bi-weekly times 4 weeks,		
	•	eturn transfer to HC			and then at least quarterly		
	` ′	of resident. Writer call			ongoing. The Quality Assuran Performance Improvement aud		
	` ´ ´	sis center) to inquire			will be reviewed by the monthly		
		d by [staff named] that he			Quality Assurance Performance	· I	
	1	/t (due to) not being able			Improvement committee. By		
	to access shunt	<b>"</b>			what date will the systemic		
					changes be completed? February 1, 2015		
	•	iew on 1/8/2015 at 10:42			1 ebidary 1, 2013		
	· ·	r of Nursing Services					
	` ′	Resident #123 went to					
	_	er on 1/7/15. She					
	indicated the dia	lysis center did not					
	return a commun	nication form sent with					
	the resident to th	e appointment. The					
	DNS indicated the	ne van driver who					
	transported the re	esident informed the					
	facility Resident	#123 did not receive					
	dialysis on 1/7/1	5 because the port was					
	not able to be acc	cessed. She indicated					
	the facility sent a	a communication form to					
	all appointments	, but the dialysis center					
	did not consisten	tly return the form. The					
	DNS indicated the	ne facility did not have a					
	book for recording	ng dialysis information					
	or for tracking re	eceipt of the					
	communication f	form. The DNS					
	indicated nurses	should palpate and					
		sidents fistula (port for					
	receiving dialysi	s) and record the					
	residents blood p	pressure on the					
	Medication Adm	ninistration Record					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	A. BUILDING COMPLETED			
		155505	B. WIN	G		01/09/	2015
	PROVIDER OR SUPPLIER			6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΤE	(X5) COMPLETION DATE
F000309 SS=D	(MAR), upon the the dialysis center.  During an interval, the DNS in not been develop.  3.1-35(a)  483.25 PROVIDE CARE/SHIGHEST WELL Exacts resident must provide their services to attain opracticable physic psychosocial well-the comprehensive care.  Based on record the facility failed communicating of status during/foll 1 of 1 resident re(Resident #123).  Findings include Resident #123's a diagnosis include to, Stage IV CKI Disease) and the	iew on 1/9/15 at 10:15 dicated a care plan had bed for dialysis.  SERVICES FOR BEING SET receive and the facility necessary care and for maintain the highest al, mental, and being, in accordance with the assessment and plan of  review and interview, It to ensure a system for care provided and health lowing hemodialysis for eviewed for dialysis care	F00	0309	It is the practice of the provide ensure that pertinent care provided, and health status du and following hemodialysis, is communicated. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? Resident #123 has been discharged from the community. How other residents having the potentiate to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken? The community will continue to sen written request for information pertaining to the care provided and health status during and	ve ed m e	DATE 02/01/2015

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	DING 00		COMPLETED	
		155505	A. BUII B. WIN			01/09/	2015	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	L			OBIN RUN W			
ROBIN R	UN HEALTH CENT	FR			APOLIS, IN 46268			
			1			1		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION DATE	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	following hemodialysis, with ea	ach	DATE	
	days a week.				resident in transport to a	aC11		
					scheduled hemodialysis			
	The treatment re	cord, dated			treatment. In the event that the	е		
	1/1/15-1/31/15, i	indicated the AV fistula			written information is not receive	ved		
	(access site used	for receiving dialysis)			upon return to the community,	the		
	was supposed to	be checked daily and the			community will reach out via			
	thrill palpated 3				phone to obtain this informatio			
		F			What measures will be put in	to		
	A "Daily Skilled	Nurse's Note," dated			place or what systemic changes will be made to			
	_	m., indicated, "Received			ensure that the deficient			
					practice does not recur? The			
		portation that Dialysis			community will continue to sen			
	•	eturn transfer to HC			written request for information			
	(Health Center)	of resident. Writer call			pertaining to the care provided	l,		
	(sic) FNC (dialy	sis center) to inquire			and health status during and			
	reason. Was told	d by [staff named] that he			following hemodialysis, with ea	ach		
	did not dialyze d	/t (due to) not being able			resident in transport to a scheduled hemodialysis			
	to access shunt				treatment. In the event that the	Δ		
					written information is not receive	-		
	During an interv	iew on 1/8/2015 10:38			upon return to the community,			
	_				community will reach out via			
		ger # 3, indicated the			phone to obtain this informatio	n.		
	nurses usually se				How the corrective action(s)			
		form to dialysis with			will be monitored to ensure t			
	•	nowever, the dialysis			deficient practice will not rec	ur,		
	center did not alv	ways return those forms.			i.e., what quality assurance program will be put into place	02		
					A Quality Assurance Performa			
	During an interv	iew on 1/8/2015 at 10:42			Improvement audit tool will be			
	a.m., the Directo	or of Nursing Services	1		utilized daily times 4 weeks, th			
	· ·	Resident #123 went to			weekly times 4 weeks, and the			
	` ′	er on 1/7/15. She			at least quarterly ongoing. The			
	-	lysis center did not			Quality Assurance Performance	e		
		nication form sent with			Improvement audits will be reviewed by the monthly Quali	tv		
					Assurance Performance	· y		
		e appointment. The			Improvement committee. By			
		he van driver who			what date will the systemic			
	transported the r	esident informed the			changes be completed?			

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE S COMPLE	
MULLAN	155505	A. BUILDING	00	01/09/2	
	100000	B. WING	ADDRESS CITY COATE OF COATE		-0.10
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W		
ROBIN F	UN HEALTH CENTER		IAPOLIS, IN 46268		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	<u> </u>	I	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI	O BE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	DATE
	facility Resident #123 did not receive		February 1, 2015		
	dialysis on 1/7/15 because the port was				
	not able to be accessed. She indicated				
	the facility sent a communication form to				
	all appointments, but the dialysis center				
	did not consistently return the form. The				
	DNS indicated the facility did not have a				
	book for recording dialysis information				
	or for tracking receipt of the				
	communication form. The DNS				
	indicated nurses should palpate and				
	auscultate the residents fistula (port for				
	receiving dialysis) and record the				
	residents blood pressure on the				
	Medication Administration Record				
	(MAR), upon the resident's return from				
	the dialysis center.				
	During an interview on 1/8/15 at 2:30				
	p.m., LPN # 11 indicated she sent a				
	Dialysis Communication Form to the				
	dialysis center with the resident. She				
	indicated she had not received a sheet				
	back for Resident #123 on 1/7/15 when				
	he returned from treatment.				
	During an interview on 1/9/15 at 10:15				
	a.m., the DNS indicated there were no				
	completed Dialysis Communication				
	Forms in Resident #123's record and				
	indicated a care plan for dialysis had not				
	been developed.				
	ocen developed.				
	A policy entitled, "Dialysis Care,"				

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Facility ID: 001156

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPLETED 01/09/2015	
		155505	B. WIN			01/09/	2015
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  OBIN RUN W		
ROBIN R	UN HEALTH CENT	ER			APOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
	1/8/15 indicated "Complete the D	e DNS at 11:00 a.m. on the facility was to, vialysis Communication					
	Form and send to the dialysis center with the resident for each visit. This form						
	_	eted by the dialysis					
		ned with the resident."					
		urther indicated, "Upon nmunity from the dialysis					
		nt will have their vital					
	signs and access site checked for bleeding and recorded in the resident						
	medical record						
	3.1-37(a)						
F000371 SS=E	The facility must - (1) Procure food fit considered satisfal local authorities; a (2) Store, prepare under sanitary cor Based on observing record review, the adequate hand satisfatibution and assistance to 15 dining observation (Care) dining room	rom sources approved or actory by Federal, State or and additions ation, interview and are facility failed to ensure anitation during food while providing feeding residents for 3 of 3 ons in 1 of 2 (Memory ms (Residents #19, #27, 43, #48, #49, #54, #59,	F000	0371	It is the practice of the provide ensure adequate hand sanitati is maintained during food distribution and feeding assistance. What corrective action(s) will be accomplishe for those residents found to have been affected by the deficient practice? Residents #19, #27, #34, #38, #39, #43, #48, #49, #54, #61, #63, #72, #80, #90 have been monitored	on e <b>d</b>	02/01/2015

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Event ID:

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STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MUL		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155505	B. WING		01/09/2015	
		1		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		ROBIN RUN W		
ROBIN R	RUN HEALTH CEN	TER		NAPOLIS, IN 46268		
				1,4 0210, 11 10200		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA	COMPLETION DATE	
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE	
	Findings include	2.		and are not currently exhibiting any signs or symptoms of act	-	
				infection. Resident #59 has b		
	1. On 1/5/14 at 1	1:17 p.m., during the		discharged from the commun		
	lunch dining obs	servation, Certified		CNA #8, CNA #9, and Memor	,	
	Nursing Assista	nt (CNA) #8 was		Care Coordinator #7 have be		
	observed to wip	e Resident #49's mouth		educated on proper technique	e for	
		ith both hands before she		food distribution and feeding		
	_	t #34 a spoonful of food		assistance. How other reside	ents	
	with her left han	•		having the potential to be affected by the same deficie	nt	
	with her left han	iu.		practice will be identified an		
	0 1/0/17 0	10.50		what corrective actions(s) w		
		12:59 p.m. to 1:08 p.m.,		be taken? CNA #8, CNA #9,		
		dining observation,		Memory Care Coordinator ha		
	Memory Care C	oordinator #7 placed both		been educated on proper		
	of his hands on	Resident #43's shoulders		technique for food distribution	and	
	before he retriev	red and set up two dessert		feeding assistance. What		
	dishes for Resid	ent #43 and Resident		measures will be put into pla		
	#48. He was the	n observed to place his		or what systemic changes w	/ill	
		mouth and rubbed his		be made to ensure that the		
	_	red and set up dessert for		deficient practice does not recur? All Healthcare Center		
	_	•		associates will be educated o	n l	
		ext, he was observed to		proper technique for food		
	1 -	and on Resident #63's		distribution and feeding		
		his left hand to wipe		assistance. How the correcti	ve	
	Resident #63's n	nouth with a napkin. He		action(s) will be monitored t		
	was then observ	ed to use both hands as		ensure the deficient practice		
	he wiped down	Resident #63's table with		will not recur, i.e., what qual	-	
	the soiled napking	n. Next, he removed		assurance program will be p		
	_	oiled clothing protector		into place? A Quality Assura Performance Improvement au		
		hands before he patted		tool will be utilized 3 times we		
		eack with his left hand		times 4 weeks, then two times	,	
				weekly times 4 weeks, and th		
	_	ose with his right hand.		at least quarterly ongoing. The		
		served to pat Resident		Quality Assurance Performan	ce	
		with his right hand and		Improvement audits will be	1:4.	
	_	nbs off the resident's lap		reviewed by the monthly Qua Assurance Performance	iity	
	with his left han	d. He then adjusted		Assurance i chomiance		

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PRINTED: 02/02/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPI		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	(3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		DING 00		COMPLETED	
155505			B. WIN			01/09/	2015	
NAME OF I	DROVIDED OD SLIDDLIEE		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIEF			6370 R	OBIN RUN W			
	RUN HEALTH CENT			<u> </u>	APOLIS, IN 46268			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	Improvement committee. By what date will the systemic changes be completed? February 1, 2015		DATE	
		oot rest with both hands						
		to wipe down Resident						
		oth hands. Next, he						
		up two dessert dishes			<b>,</b> ,			
		and Resident #90 with						
		s. The Memory Care						
	Coordinator #7 v	was not observed to						
	perform hand sa	nitation in between						
	feeding assistant	ce and resident care.						
	During an observation on 1/9/15 at 1:13							
	p.m., CNA #9 used her right hand to							
	wipe Resident #34's mouth with her							
	_	rotector before she						
		:#49 a spoonful of food						
		nd. CNA #9 was not						
		form hand sanitation in						
	_	assistance provided for						
	Resident #49 and	•						
		ions on 1/9/14 from 8:55						
		., the Memory Care						
		CC) was observed						
	_	ts during the breakfast						
		was not observed to						
		between resident to						
		or utilize gloves during						
	the following ob	servations:						
	The MCC touch	ed Resident #59's arm						
	with his hand the	en picked up Resident						
		nis right hand and put it						
		4's hand. The MCC						
		ent #27's fork and put it						
		d used his hand to guide						
	into nei mana am	a asea ms nama to guide						

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PRINTED: 02/02/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	OO	(X3) DATE COMPL		
155505			LDING	00	01/09/		
100000			B. WIN		PRESENTE CONTROL OF CORP.	01/03/	2010
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W		
ROBIN RUN HEALTH CENTER					APOLIS, IN 46268		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		outh. The MCC touched					
		heelchair, patted her on					
	•	the right side of his					
		ed soiled clothing					
	1 ^	the tables. The MCC					
		ent #80's fork and cut her					
		the MCC touched					
		rm, touched the left side					
		nen proceeded to touch					
	Resident #39's hand.						
	During an interview on 1/9/15 at 1:19						
	p.m., Licensed Practical Nurse (LPN)						
	#10 indicated staff should have washed						
		they became soiled, or					
		vas touched, before					
		ce or resident care was					
	provided to a dif						
	A policy titled "	nandwashing/Hand					
		ied as current by the					
		1/9/14 at 2:30 p.m.,					
		e facility considers hand					
	· ·	hary means to prevent the					
	1	ons All personal shall					
	_	vashing/hand hygiene					
		lp prevent the spread of					
	1 ^	er personnel, residents,					
		efore and after direct					
		(for which hand hygiene					
	1	cceptable professional					
		re and after handling					
		nd after assisting a					
	resident with me	als After handling					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155505		(X2) MULTIPI	(X3) DATE SURVEY COMPLETED 01/09/2015			
NAME OF PROVIDER OR SUPPLIER  ROBIN RUN HEALTH CENTER		B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  6370 ROBIN RUN W  INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	CROSS-REFERENCED TO THE APPRO	BE COMPLETION	
F000464 SS=E	soiled equipment 3.1-21(i)(2) 3.1-21(i)(3) 483.70(g) REQUIREMENTS ACTIVITY ROOM The facility must designated for result and the main dining observations. (Full 19, #29, #70, and #1).  Findings included On 1/5/15 at 12 was observed sit table and an unit sitting in a dining Resident #25. If #25 away from certified nursing	S FOR DINING & MS provide one or more rooms sident dining and activities.  Set be well lighted; be well consmoking areas identified; rnished; and have sufficient modate all activities.  Vation and interview, the rensure sufficient space to cted passage of residents' I walkers during dining in room for 2 of 2 dining Residents #25, #160, #56, #106, #51, #28, #124,	F000464	It is the practice of the provensure sufficient space to punobstructed passage of rewheelchairs and walkers didining. What corrective action(s) will be accomplifor those residents found have been affected by the deficient practice? The ID reviewed and revised the tapositioning in the Dining Reensure unobstructed pathwall resident. How other reshaving the potential to be affected by the same deficient practice will be identified what corrective actions(s) be taken? The IDT has revand revised the table position the Dining Room to ensure unobstructed pathways for resident. What measures we put into place or what systems will be made to	shed to T has able com to vays for idents  cient and ) will viewed oning ure all will be	

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A BUILDING B	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
NAME OF PROVIDER OR SUPPLIER  ROBIN RUN HEALTH CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  #25 and the unidentified resident.  On 1/05/15 at 12:42 p.m., Resident #56 was observed to lift her walker up over the unidentified resident #25's wheelchair because Resident #25's wheelchair because Resident #56's walker would not fit between the wheelchair and dining room chair.  On 1/05/15 at 1:07 p.m., unit manager (UM) #3 moved Resident #119 to allow 3 unidentified residents leaving the dining room in wheelchairs to move between Resident #119's wheelchair and the unidentified resident sitting in a dining room chair directly behind her.  On 1/09/15 at 12:36 p.m., Resident #29 what date will the systemic changes be completed?	AND PLAN OF CORRECTION IDENTIFICATION N		IDENTIFICATION NUMBER:	A BUILDING 00		COMPLETED		
ROBIN RUN HEALTH CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Was observed to lift her walker up over the unidentified resident sitting in a dining room chair and dining room chair.  On 1/05/15 at 1:07 p.m., unit manager (UM) #3 moved Resident #119 to allow between Resident #119's wheelchair to move between Resident #119's wheelchair and the unidentified resident sitting in a dining room chair directly behind her.  On 1/09/15 at 12:36 p.m., Resident #29 was observed sitting in her wheelchair and the unidentified resident #29 was observed sitting in her wheelchair and was observed sitting in a dining room chair directly behind her.  STREET ADDRESS, CITY, STATE, ZIP CODE (370 ROBIN RUN W INDIANAPOLIS, IN 46268  STREET ADDRESS, CITY, STATE, ZIP CODE (370 ROBIN RUN W INDIANAPOLIS, IN 46268  ID PREFIX (EACH DEFICIENCY) (X5)  COMPLETION DATE  ON 1/05/15 at 12:42 p.m., Resident # 56  was observed to lift her walker up over the unidentified resident #56  was observed to lift her walker up over the unidentified resident #25's wheelchair and the unidentified resident #19 to allow a unidentified resident #119 to allow a dining room in wheelchairs to move between Resident #119's wheelchair and the unidentified resident sitting in a dining room chair directly behind her.  On 1/09/15 at 12:36 p.m., Resident #29 what date will the systemic changes be completed?			155505	A. BUILDING 01/09/2015			2015	
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INDIANAPOLIS, IN 46268   INDIANAPOLIS, IN 46268	NAME OF PROVIDER OR SUPPLIER							
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  #25 and the unidentified resident.  On 1/05/15 at 12:42 p.m., Resident # 56 was observed to lift her walker up over the unidentified resident sitting in a dining room chair and Resident #25's walker would not fit between the wheelchair and dining room chair.  On 1/05/15 at 1:07 p.m., unit manager (UM) #3 moved Resident # 119 to allow 3 unidentified residents leaving the dining room chair for move between Resident #119's wheelchair and the unidentified resident sitting in a dining room chair directly behind her.  On 1/09/15 at 12:36 p.m., Resident #29 was observed sitting in her wheelchair at the deficient practice does not recur? The IDT has reviewed and revised the table positioning in the Dining Room to ensure unobstructed pathways for all resident. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? A Quality Assurance Performance Improvement audit tool will be utilized 3 times weekly times 4 weeks, then two times weekly times 4 weeks, and then at least quarterly ongoing. The Quality Assurance Performance Improvement committee. By what date will the systemic changes be completed?	DODINI D	UINI HEALTH CENT	ED					
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On 1/05/15 at 1:07 p.m., unit manager  (UM) #3 moved Resident # 119 to allow 3 unidentified residents leaving the dining room in wheelchairs to move between Resident #119's wheelchair and the unidentified resident sitting in a dining room chair directly behind her.  On 1/09/15 at 12:36 p.m., Resident #29 was observed sitting in her wheelchair at  Improvement audit tool will be utilized 3 times weekly times 4 weeks, then two times weekly times 4 weeks, and then at least quarterly ongoing. The Quality Assurance Performance Improvement audits will be reviewed by the monthly Quality Assurance Performance Improvement committee. By what date will the systemic changes be completed?		wheelchair and o	lining room chair.			program will be put into plac	e?	
(UM) #3 moved Resident # 119 to allow 3 unidentified residents leaving the dining room in wheelchairs to move between Resident #119's wheelchair and the unidentified resident sitting in a dining room chair directly behind her.  Utilized 3 times weekly times 4 weeks, then two times weekly times 4 weeks, and then at least quarterly ongoing. The Quality Assurance Performance Improvement audits will be reviewed by the monthly Quality Assurance Performance Improvement committee. By what date will the systemic changes be completed?		-					nce	
weeks, then two times weekly times 4 weeks, and then at least quarterly ongoing. The Quality Assurance Performance Improvement audits will be reviewed by the monthly Quality Assurance Performance Improvement committee. By was observed sitting in her wheelchair at								
3 unidentified residents leaving the dining room in wheelchairs to move between Resident #119's wheelchair and the unidentified resident sitting in a dining room chair directly behind her.  On 1/09/15 at 12:36 p.m., Resident #29  was observed sitting in her wheelchair at							•	
dining room in wheelchairs to move between Resident #119's wheelchair and the unidentified resident sitting in a dining room chair directly behind her.  On 1/09/15 at 12:36 p.m., Resident #29 was observed sitting in her wheelchair at  at the total, at a thord with directly ongoing. The Quality Assurance Performance Improvement audits will be reviewed by the monthly Quality Assurance Performance Improvement committee. By what date will the systemic changes be completed?		` ′					et	
between Resident #119's wheelchair and the unidentified resident sitting in a dining room chair directly behind her.  Assurance Performance Improvement audits will be reviewed by the monthly Quality Assurance Performance Improvement committee. By what date will the systemic changes be completed?						The state of the s		
the unidentified resident sitting in a dining room chair directly behind her.  On 1/09/15 at 12:36 p.m., Resident #29  was observed sitting in her wheelchair at Improvement audits will be reviewed by the monthly Quality Assurance Performance Improvement committee. By what date will the systemic changes be completed?		_					,	
dining room chair directly behind her.  On 1/09/15 at 12:36 p.m., Resident #29  was observed sitting in her wheelchair at								
On 1/09/15 at 12:36 p.m., Resident #29 was observed sitting in her wheelchair at Improvement committee. By what date will the systemic changes be completed?			C			reviewed by the monthly Quali	ty	
On 1/09/15 at 12:36 p.m., Resident #29 was observed sitting in her wheelchair at what date will the systemic changes be completed?		dining room cha	ir directly behind her.					
was observed sitting in her wheelchair at changes be completed?						=		
		On 1/09/15 at 12	2:36 p.m., Resident #29			_		
		was observed sit	ting in her wheelchair at					
a table and Resident #70 was observed February 1, 2015		a table and Resid	dent #70 was observed			February 1, 2015		
sitting in his wheelchair directly behind		sitting in his who	eelchair directly behind					
her. The director of nursing (DON)		_						
moved Resident #29's wheelchair closer			• , ,					
		to the table. Then the DON moved Resident #70 away from the table in						
order for UM #3 to move Resident #106's								
wheelchair through to his table.		wheelchair through to his table.						
On 1/09/15 at 1:06 p.m., Resident #56		On 1/09/15 at 1:	06 p.m., Resident #56					
was observed to be unable to fit her		was observed to	be unable to fit her					
walker between Resident # 51's		walker between	Resident # 51's					
wheelchair and Resident #28's								
wheelchair. The administrator and								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE COMPL		
155505			LDING		01/09/		
			B. WIN		DDRESS, CITY, STATE, ZIP CODE	0 1/00/	
NAME OF PROVIDER OR SUPPLIER				1	OBIN RUN W		
ROBIN R	UN HEALTH CENT	ER			APOLIS, IN 46268		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG				PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710	activities director were observed assisting			mo	·		DATE
		stabilizing her from					
	_	#3 lifted the walker					
		s' wheelchair wheels.					
	On 1/09/15 at 1:	11 p.m., Resident #124					
	was observed to	be unable to pass					
	between Resider	nt #70's wheelchair and					
		heelchair when exiting					
	•	The administrator was					
	observed moving Resident #70's						
	wheelchair up closer to table and guided						
	Resident #124's wheelchair by grabbing						
	the leg bar and pulled her through the gap						
	between Resident #70's wheelchair and						
	Resident #29's wheelchair.						
	On 1/09/15 at 1:	16 p.m., Resident #1 was					
		nable to pass between					
		heelchair and Resident					
	#29's wheelchair	. UM #3 moved					
	Resident #70 aw	ay from table so					
	Resident #1 was	able to fit through and					
	exit the dining room.						
	During an interv	iew on 1/09/15 at 1:21					
		icated there was a					
	•	residents to and from					
		tables had been recently					
		laced back into the					
	_	She also indicated it was					
		ding on where the					
	residents sat.	-					
1							

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	TO OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED			
	155505	B. WING		01/09/2015			
NAME OF P	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATE, ZIP CODE				
			OBIN RUN W				
ROBIN R	UN HEALTH CENTER	INDIANAPOLIS, IN 46268					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA				
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE			
	During an interview on 1/09/15 at 1:28						
	p.m., CNA #4 indicated it was not						
	unusual for the staff to move the						
	residents up closer to the table or						
	temporarily out of the way to allow other						
	residents to pass by them. She indicated						
	the residents sat in different locations for						
	different meals and depending on which						
	residents were seated near each other it						
	happened more often.						
	~~						
	During an interview on 1/09/15 at 1:54						
	p.m., the administrator indicated she was						
	aware they needed to occasionally assist						
	residents to and from their tables past						
	other residents. She indicated there was						
	no policy regarding dining room spacing						
	or accommodations.						
	of accommodations.						
	2.1.10(m)(4)(D)(ii)						
	3.1-19(w)(4)(B)(ii)						
F009999							
	3.1-14 PERSONNEL	F009999	It is the practice of the provide ensure that all Healthcare Cer	0 - 1 0 - 1 - 0 - 0			
	(k) There shall be an organized ongoing		associates receive required	iter			
	inservice education and training program		dementia training. What				
	planned in advance for all personnel.		corrective action(s) will be				
	This training shall include, but not be		accomplished for those				
	limited to, the following:		residents found to have been	n			
	(5) Needs of specialized populations		affected by the deficient	.			
	served.		practice? Therapist (PT) #1 a				
			#2 have completed 3 hours of dementia training. <b>How other</b>				
	This state rule was not met as evidenced		residents having the potentia				
1	Timb blace rate was not met as evidenced	I	naving the potenti				

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CENTERS TO	THE WILLIAM	SHID SERVICES				0.11	B 110.0700 0071
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, pull paic 00		00	COMPLETED		
155505			A. BUILDING			01/09/2015	
			B. WIN				
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
					OBIN RUN W		
ROBIN R	RUN HEALTH CEN	TER		INDIAN	IAPOLIS, IN 46268		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	T	1	(X5)
PREFIX					PROVIDER'S PLAN OF CORRECTION		` ′
	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG			DATE
	by:				to be affected by the same		
					deficient practice will be		
	Based on emplo	yee record review and			identified and what correctiv	'e	
	_				actions(s) will be taken?		
		cility failed to ensure 2 of			Therapist (PT) #1 and #2 have	e	
	2 therapy emplo	yees had completed			completed 3 hours of dementi	a	
	dementia trainin	ıg.			training. What measures will	be	
					put into place or what syster	nic	
	Findings include:  Employee records were reviewed on				changes will be made to		
					ensure that the deficient		
					practice does not recur? All		
					associates in the Therapy		
		a.m. The record indicated			department will complete 3 hours		
					of dementia training now, and		
	Physical Therapist (PT) #1 was hired on				have been placed on the		
	4/10/07 and PT	#2 was hired on 5/12/08.			schedule for this training on a	n	
	The record lacks	ed evidence PT #1 or PT			annual basis. How the		
	#2 had complete	ed the required inservice			corrective action(s) will be		
	-	-			monitored to ensure the		
	training for care of residents with				deficient practice will not red	eur.	
	dementia.				i.e., what quality assurance	,	
					program will be put into place	e?	
	During an interv	view on 1/9/14 at 11:45			The Administrator will review to		
	_				schedule for dementia training		
p.m., the Administrator stated, "It is not				each month, cross-reference t	<i>'</i>		
	"corporation named" practice for therapist to have dementia training." She indicated the therapy department took care of residents with dementia daily.  During an interview on 1/9/14 at 12:16				with the actual attendance, in		
					order to ensure that all		
					Healthcare Center associates		
					remain in compliance with the		
					required annual dementia trail		
					throughout the year. By what	-	
		istrator indicated she was			date will the systemic chang		
	unable to find a	policy regarding			be completed? February 1,		
	dementia trainin	ig requirements for			2015		
	employees.	<u> </u>					
	chipioyees.						
	l		- 1		1		

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